



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Muhammad M. Farooqi, MD

Respondent Name

Commerce & Industry Insurance

MFDR Tracking Number

M4-14-1646-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured workers claim be reviewed for additional monies"

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 18, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 8, 2013	Designated Doctor Examination	\$800.00	\$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
- 1 – (18) Duplicate claim/service.
 - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice). (U301)

Issues

1. What is the total allowable for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is \$350.00.

This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that "(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) **upper extremities and hands**; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; (D) ... (i) Non-musculoskeletal body areas are defined as follows: (I) **body systems**; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides... (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150" [emphasis added].

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the right shoulder and chest wall. The examination of the right shoulder included a full physical examination with range of motion. Therefore the correct MAR for this examination is \$300.00.

The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the chest wall in the Respiratory System chapter. For this reason, it is considered a body system in the non-musculoskeletal category. Therefore, the correct MAR for this examination is \$150.00.

2. Review of the submitted documentation finds that the insurance carrier did not support a reason to deny payment for the disputed services as required by 28 Texas Administrative Code §133.240. The Division finds that the requestor billed correctly for the services rendered. The total allowable for the disputed services is \$800.00. The insurance has paid \$0.00. Therefore, the requestor is entitled to reimbursement of \$800.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

February 10, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.